Relapse Prevention and the Substance-Abusing Criminal Offender

An Executive Briefing

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8

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Foreword

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for expanding available and effective services to treat addiction. No group needs these services more acutely than offenders involved in the criminal justice system. We know that a high percentage of criminal offenders have problems with alcohol and other drugs. One survey indicates that 62 percent of inmates in State and Federal prisons—almost two of every three inmates—used drugs on a regular basis prior to their incarceration. In many metropolitan areas, more than 70 percent of arrestees test positive for drugs.

Not just the individual, but all of society, benefits when we can help offenders avoid relapse to alcohol and other drug abuse. Relapse to drug use accelerates the level of subsequent criminal activity. Offenders who use drugs are involved in more crime days than offenders who do not use drugs. Specialized relapse prevention treatment can help offenders learn skills that they badly need to avoid the vicious cycle of relapse and return to criminal behavior.

First, it has been established that addiction is a chronic, relapsing disorder; the gains made during treatment are often lost following any patient's return to the community. All offenders face difficulties adjusting to custody fluctuations. Sometimes the pressures of probation or parole supervision trigger relapse. Others experiencing the transition from incarceration back to life in the community face an extremely difficult period of readjustment. At this time, they are particularly vulnerable to relapse.

Second, it has been clearly established that there are a host of physiological, psychological, and environmental factors that contribute to the onset and maintenance of addiction. Addiction is one of the most complex biopsychosocial diseases known to science. All of these factors tend to converge for the offender, whose addiction simply cannot be treated in isolation from his or her primary health, mental health, or socioeconomic deficits and disorders. The offender, at a time of extreme stress, must reenter the community without the supports available to most other patients. Many offenders may have weakened or no family ties, deficits in educational and vocational skills, no job, and long-standing problems in handling anger and stress. Such individuals are at great risk of relapse to addiction by virtue of their extreme socioeconomic dislocation and their exposure to drug-using associates, crime, poverty, homelessness, and other high-risk situations conducive to relapse.

CSAT is dedicated to working collaboratively with the criminal justice system at all levels—Federal, State, county, and municipal—to intervene with this highly vulnerable population of drug-using patients. We need to provide offenders with access to relapse prevention therapy, so they can learn the techniques and skills to help them identify and overcome their own individual "triggers" to relapse. And, working together, personnel in the criminal justice and community drug treatment systems need to develop cooperative arrangements so that offenders may move from relapse prevention programs within criminal justice facilities to similar programs within their communities.

My hope is that this report will encourage the treatment field and agencies of the criminal justice system to forge stronger linkages with each other and to coordinate their efforts and resources on behalf of offenders who have alcohol and other drug problems. I believe you will find this document to be a valuable tool and reference for setting up and enhancing relapse prevention approaches in your own institution and community.

Lisa W. Scheckel
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Executive Summary

Programs designed to address relapse prevention are a critical component of alcohol and drug abuse treatment for criminal justice populations. Relapse to drug use is a common problem for recovering individuals—it is one of many symptoms of the condition of alcohol and other drug dependency. Even after the most intensive course of substance abuse treatment, many patients are vulnerable to a return to using drugs or alcohol. Many offenders, even when they are motivated to follow aftercare recommendations, may be unable to maintain abstinence without help and treatment in a specialized relapse prevention program.

Treatment programs within the criminal justice system and within communities can greatly benefit this vulnerable population by helping patients build their relapse prevention skills as part of the treatment process. This report can be useful as a tool for those who (1) want to understand the process of addiction and relapse and (2) want to plan or set up relapse prevention programming for persons under criminal justice supervision, whether they are in custody or diversion, on probation, in community corrections, or supervised by parole agencies.

Why Offenders Are Especially Vulnerable to Relapse

Offenders tend to be ill-equipped to handle the stressful situations that can bring about relapse, while at the same time they suffer from stresses both more numerous and intense than those affecting the usual patient. Upon release from custody, the offender must immediately assume the unfamiliar task of being responsible for self, while simultaneously attempting to resume family relationships, locate employment, comply with requirements of parole or probation, and resist the temptations presented by drug-using associates or family members. Faced with a myriad of decisions and often with little positive support, the offender frequently succumbs to drug use to ease feelings of failure, anxiety, confusion, and depression. The cycle of alcohol and other drug abuse and related criminal activity then begins anew.

Criminal offenders are particularly vulnerable to relapse because alcohol and other drug abuse, for them, is often a method for coping with stress. Therefore, patients who demonstrate antisocial behavior and criminal activity are often most in need of help in learning constructive methods for coping with stress. Relapse is most often triggered by such stress as anxiety, isolation, positive and negative social pressures, and depression. Extreme and varied stress is a typical experience among offenders as they leave the restricted environment of a prison, and, to a lesser extent, for those leaving a period of close community custody and surveillance. Often, the returning offender must face these stresses without stable employment or the support of a stable home and social environment. Lacking successful coping strategies and social support, the offender often returns to drug abuse as the familiar coping strategy.

To avoid relapse, recovering patients must draw on their inner strengths, self-awareness, and coping skills, as well as on their social and family supports. This task is made more difficult for offenders, because so many of them experience multiple and long-standing psychosocial problems. These problems, which contribute both to their criminal behavior and to the potential for relapse, may include:

- Difficulty in relating to family members
- An inability to sustain long-term relationships
- Emotional and psychological difficulties
- Deficits in educational and vocational skills
- Employment problems

- Multiple contacts with the criminal justice system
- Inability to handle anger and stress
- Inability to handle social pressures for drug use
- Inability to handle high-risk situations conducive to relapse

How Relapse Can Be Prevented

A relapse to alcohol and other drug dependency is not an immediate or unpredictable event. Each person has a set of individual triggers, high-risk situations, or associates which set in motion the gradual process of relapsing to uncontrolled drug abuse. Researchers and treatment practitioners have developed various methods to help patients identify those areas which present threats to their abstinence. Once identified, recovering patients may be able to control and overcome these threats by use of strategies designed to increase self-awareness, strengthen resistance, and create positive coping options.

This executive briefing book presents one approach for helping offenders develop the requisite skills for preventing relapse. This approach is based on the idea that recovery is a process that takes place over time and in specific stages. To accomplish the tasks, the patient needs to be aware of this progression and to gain the skills needed to master each stage. The strategy defines recovery in terms of six stages: (1) transition to accepting the goal of abstinence, (2) physical and psychological stabilization, (3) early recovery, (4) middle recovery, (5) late recovery, and (6) maintenance. Treatment programs for relapse-prone patients need to be designed to provide help in the following areas:

- Self-regulation and physical, psychological, and social stabilization
- Self-assessment to help patients reach a conscious understanding and acceptance of the situations/events leading to their past relapses
- Understanding of the general causes and dynamics of relapse
- Development of coping skills for responding to their individual stressors and warning signs of relapse
- Development of recovery activities to help recognize and manage each personal warning sign
- Learning of daily monitoring techniques for identifying relapse warning signs
- Involvement of the patient's "significant others" in support of recovery and relapse prevention
- Maintenance and regular updating of the individual's relapse prevention plan

Where Relapse Prevention Programs Can Be Set Up

Techniques to prevent relapse are currently a component of programs at all case-processing points in the criminal justice system—diversion, probation, jail, intermediate sanctions, corrections, and parole. A number of these approaches are summarized in chapter 3. Research indicates that court-ordered treatment can be an effective vehicle for preventing relapse and recidivism among drug-abusing offenders who are unlikely to attend treatment on their own. Court-ordered treatment also tends to increase offenders' involvement in community programs and the length of time they spend in treatment.

Treatment programs within the criminal justice system need to interface with those in community treatment settings. The ideal is for staffs not just to coordinate, but to share training, the design of their programs, and the planning for individual offenders through coordinated case management procedures. An offender's treatment and relapse prevention plan, designed while the person is incarcerated or under supervision, would then be continuously in place as the individual is released to reenter the community. As offenders leave the structured criminal justice setting, they would then receive follow-up care and support in practicing their relapse prevention techniques. This continued involvement gives offenders a critical opportunity to test out their coping skills in real-life high-risk situations, to review their responses, and to be assisted throughout by counselors and other group members.

Introduction

Drug abuse treatment offers offenders an opportunity to break the cycle of drug abuse and crime. Preventing relapse—one of the common symptoms of drug dependency—is crucial for this population. For detoxified or recovering addicts involved with the criminal justice system, the relapse to drug use is likely to coincide with a return to criminal activity. The reverse is also true. A return to criminal behavior is likely to cause relapse to alcohol and other drug use.

Those in the drug treatment and criminal justice systems can do a great deal to help offenders avoid relapse. One important goal is to provide addicted or drug-abusing offenders with drug treatment that includes help in developing the personal skills and strategies needed to prevent relapse. Relapse prevention depends on a series of progressive steps that bring about fundamental change in the addict's associations, thinking patterns, value system about self and others, and the stopping of self-defeating behaviors. This report explains the components of relapse prevention as a part of the treatment process.

A second important goal is to offer continuity of care between the criminal justice system and the community after the offender's release. We can help prevent relapse by better planning for this transition and by coordinating treatment services within our communities. Every segment of the criminal justice system can play a role, such as through court-ordered and supervised drug treatment. This report suggests many relapse prevention approaches and ideas for creating community linkages among different segments of the system.

Chapter 1 provides an overview and introduction on the nature of addiction and relapse, including the types of patients affected, the goals of treatment, and strategies to promote the recovery process. The authors explain why traditional treatment models are sometimes inadequate for helping the criminal justice population. This population needs specific stabilization skills before they can focus on the change in lifestyle that is required for rehabilitation from drug abuse. Offenders need to learn specific skills to help them identify and manage the warning signs of relapse within themselves. The first chapter presents an approach for recovery that includes the development of these specific skills, and describes the principles and procedures of relapse prevention therapy.

Chapter 2 emphasizes the need to prevent relapse through program and community planning. After highlighting the personal factors and high-risk situations most likely to bring about relapse in offenders, this chapter describes program approaches for preventing relapse and the potential role that can be assumed by various segments of the criminal justice system. The author stresses the importance of strategies designed to provide graduated reentry into the community for the recovering offender. Approaches of the criminal justice and community treatment systems need to be aimed at:

- Strengthening the returning offender's motivation and commitment to treatment
- Providing an individual assessment of each offender's abuse and relapse history
- Developing a foundation of relapse prevention skills within the offender
- Providing linkages to community treatment following the offender's release from custody

Chapter 3 provides summaries of a number of specific relapse prevention programs and strategies used by local, State, and Federal criminal justice agencies. The range of program settings illustrate how relapse prevention strategies can be incorporated at all case-processing points in the criminal justice system, including diversion, probation, jail, intermediate sanctions, corrections, and parole. Many additional sources of information are listed in the section, *Other Readings*.

Chapter 1—An Overview of Addiction, Relapse, and Relapse Prevention

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Relapse is not an isolated event. Data show that relapse to alcohol and other drugs is a common event among addicts, although it is not a certain or random symptom of addiction. Many addicts experience several abstinence/relapse episodes following treatment. Studies show that the ability to resist relapse increases as the overall period of abstinence from alcohol and other drugs also increases.

Treatment practitioners recognize that relapse is a symptom of addiction, but one that may be prevented and controlled. The relapse process is marked by predictable and identifiable warning signs that begin long before the return to use or collapse occurs. These warning signs form the basis for relapse prevention programming.

Recovery and Relapse

Policymakers, administrators, and practitioners in criminal and juvenile justice agencies can benefit from information about recovery and relapse rates among patients in alcohol and drug abuse treatment programs. Knowing what is typical for the recovering population in general offers useful insights for those dealing with offenders, many of whom have problems with alcohol and drug dependency. A February 1992 report by the U.S. Department of Justice found that, of 79,000 felons in 17 States who were tracked following a sentence to probation, "the 53 percent of offenders who had a drug abuse problem were more likely to be rearrested than other offenders. Researchers also found that judges did not require drug testing or treatment for 42 percent of those known to have a drug problem" (U.S. Department of Justice 1992).

Recovery Rates for Patients

Recovery from alcohol and other drug abuse is considered a process rather than a state. In acknowledgment of this process, the American Medical Association has established criteria for recovery that are based on 3 years of abstinence from the drug of choice with no abuse of other substances. Some researchers recommend that the criteria for recovery be based on 5 years of abstinence (Bejerot 1975). Knowing that relapse may frequently and rapidly occur after treatment, members of Alcoholics Anonymous refer to themselves as "recovering alcoholics." In studies combining a total of 499 treated alcoholics, only 18 percent remained abstinent during the 6 months following treatment (Gottheil et al. 1982).

Relapse also may occur frequently and rapidly following treatment for dependency on other drugs. A study conducted by Maddux and Desmond (1981) showed that "70 percent of 1,653 treatment and correctional interactions over a mean period of 20 years were followed by less than 1 month of abstinence. Eighty-seven percent [of interactions] were followed by abstinence of less than 6 months." Another study conducted by Simpson, Joe, and Bracy (1982) found that "56 percent to 77 percent of opioid addicts in different treatment groups resumed opioid use within 1 year after completion of treatment."

Although studies indicate that relapse is part of the recovery process for many patients, other studies of lifelong recovery/relapse patterns indicate that patients are not without hope. Approximately one-third of patients achieve permanent abstinence through their first attempt at recovery. Another one-third have a period of brief relapse episodes that eventually result in long-term abstinence. An additional one-third have chronic relapses that result in eventual death from addiction. These percentages are consistent with lifelong recovery rates from any chronic lifestyle-related illness (Vaillant 1966). Approximately one-half of all relapse-prone patients eventually achieve permanent abstinence, while many others improve despite having periodic episodes of relapse.

Categories of Patients

For the purpose of relapse prevention therapy, individuals addicted to alcohol and other

drugs can be categorized according to their recovery and relapse histories (Gorski and Miller 1986). These categories are:

- Patients prone to recovery
- Patients briefly prone to relapse
- Patients chronically prone to relapse

Relapse-prone individuals can be further divided into the following three distinct subgroups: transition patients, unstabilized relapse-prone patients, and stabilized relapse-prone patients.

1. Transition patients. In spite of adverse consequences, transition patients fail to recognize or accept the fact that they are suffering from alcohol and other drug addiction. This is usually because the chemical has disrupted the patient's ability to perceive reality accurately.

2. Unstabilized relapse-prone patients. Unstabilized patients have not been taught the skills they need to identify their symptoms of addiction and addictive preoccupation. In these cases, the treatment fails to provide these patients with the skills needed to interrupt their disease progression and to alter their alcohol and other drug use. As a result, such patients are unable to adhere to a recovery program requiring abstinence, treatment, and lifestyle change.

3. Stabilized relapse-prone patients. Stabilized patients recognize that they are dependent on alcohol or other drugs, that they need to maintain abstinence to recover, and that they need to maintain an ongoing recovery program if they are to remain abstinent. Such ongoing efforts usually mean either patient involvement with a 12-Step program or other protracted efforts at psychological and physical rehabilitation. However, despite their efforts, these individuals develop symptoms of dysfunction that eventually lead them back to alcohol or other drug abuse.

Many therapists mistakenly believe that most relapse-prone addicts are not motivated to recover. This belief is particularly common among those who work with addicts in the criminal justice system, where relapse to drug use coincides with a return to criminal activity. However, clinical experience does not support this perception. The relapse prevention center at Father Martin's Ashley, in Havre de Grace, Maryland, admits relapse-prone patients who need special help with relapse prevention. This center reports that more that 80 percent of their relapse-prone patients had a history, at the time of their earlier discharge, of both recognizing their chemical addiction and of being motivated to follow aftercare recommendations (personal communication to T. Gorski 1989). Despite this, these patients were unable to maintain abstinence and went on to seek treatment in a specialized relapse prevention program.

Relapse prevention therapy is a specialized technique that works with and builds on the strengths of current treatment methods. The principles and procedures of relapse prevention therapy can best be understood within the framework of a basic knowledge about alcoholism and other drug addiction and about the recovery process.

Alcoholism and Other Drug Addiction

Addiction is a disease caused by the continued use of alcohol or other drugs that produce biological, psychological, and social changes in an individual. These changes result in an inability to control the usage despite increasingly adverse consequences; the changes are most rapidly produced in people with a genetic predisposition to alcohol and other drug dependency. Sometimes masked by periods of physical withdrawal, the disease process is often progressive, chronic, and fatal if not interrupted by total abstinence.

The problems of alcohol and drug addiction that affect individuals while they are using, and even after they have ceased use, are:

- **Malnutrition and metabolic dysfunction**—The addict's ability to function normally is altered physically until proper diet and supplements can restore normal body chemistry. This affects the way the addict thinks, feels, and acts.
- **Liver disease and other medical complications**—The addict's liver enzymes may be radically elevated, producing toxic effects within the body. Infections, illnesses, and accidents frequently occur and need to be treated before normal functioning can resume.
- **Brain dysfunction due to the toxic effects of alcohol and drugs**—Alcohol and other drugs damage brain cells, interrupt the production of certain brain chemicals called neuro-transmitters, and alter the way the brain functions.
- **Addictive preoccupation**—Thinking patterns are altered by psychological conditioning processes, causing the patient to have strong, intrusive thoughts about drugs of choice, to have physical cravings for the drug, and to engage in compulsive behaviors aimed at seeking out and acquiring the substance. These processes also alter perception, leading to the belief that—despite adverse consequences—using is preferable to not using.
- **Social consequences**—As the physical and psychological consequences (identified above) progressively worsen, behaviors become increasingly antisocial and self-destructive. Frequent social consequences of addiction

are job loss, financial losses, car accidents, domestic violence, criminal behaviors, disease, and death.

- **Criminal behaviors**—Alcohol and other drug dependency can cause an individual to become involved in criminal behavior. Individuals who are chemically dependent commit crimes related to: (1) the effects of their use (such as drunk driving, public drunkenness, assault), (2) support of their addiction (selling drugs and illegal activities to get drugs or money for drugs), and (3) secondary consequences of their use (failure to pay child support and court fines and to follow through with probation requirements).

While some individuals do not commit crimes until they become dependent on drugs, other people have personality problems that lead to criminal behavior. Any return to criminal behavior is likely to cause relapse into alcohol and other drug use. Likewise, any relapse into alcohol and other drug use is likely to cause relapse into criminal behavior.

These conditions combine to interfere with the ability to think clearly, control feelings and emotions, and regulate behaviors—especially under stress. Dependency on alcohol and other drugs damages the basic personality formed prior to addictive use of these substances and, as the addiction progressively worsens, dependency systematically destroys meaning and purpose in life. When dependency on alcohol or other drugs begins during childhood or the teenage years, this dependency interferes with development of the emotional, social, and cognitive skills normally acquired during this life stage.

It should be noted that alcohol and other drug abusers with histories of criminal behavior frequently demonstrate antisocial problems or attitudes before the onset of their substance abuse. Among these patients, abuse increasingly interferes with their ability to regulate their own behaviors.

Treatment

Dependence on alcohol and other drugs creates problems in the physical, psychological, and social functioning of the individual. Therefore, treatment must be designed to diagnose and treat each of these three areas. The likelihood of relapse is greater when extensive damage has occurred in any of these areas of functioning. Total abstinence plus personality and lifestyle changes are essential to effect full recovery.

The type and intensity of treatment needed for each individual varies, depending on:

- The person's physical, psychological, and social problems
- Stage and type of addiction(s)
- Stage of recovery
- Personality traits and social skills prior to the onset of addiction
- Presence of complicating factors that produce undue stress

Addiction to alcohol and other drugs is viewed as a chronic disease that has a tendency toward relapse. For this reason, abstinence from alcohol and other drugs is the goal for all addiction treatment—including relapse prevention therapy. There is no convincing evidence that controlled drinking is a practical treatment goal for patients who have been physically dependent upon alcohol and other drugs.

Goals of Treatment

Treating Drug Problems, a recent report by the Institute of Medicine, states that "Lifetime abstinence from all illicit drug consumption is the central goal of drug treatment. . . . A useful shorthand for the pragmatic goal of drug treatment is that it tries to initiate, accelerate, and help sustain the recovery process" (Gerstein and Harwood 1990). The report goes on to clarify:

> The goals of the treatment delivery system are not confined to reducing the drug consumption of specific individuals. These goals, assigned overtly or implicitly by public policy or private payers, are multiple and may include the following:
>
> - Reduce the overall demand for illicit drugs
> - Reduce street crime
> - Change users' personal values
> - Develop educational or vocational capabilities
> - Restore or increase employability or productivity
> - Improve users' overall health, psychological functioning, and family life
> - Reduce fetal exposure to drug dependence

The drug abuse treatment system and the criminal justice system share the goal of reducing crime and the demand for illicit drugs. Traditionally, the justice system has exerted coercion to enter treatment on those who are criminally oriented alcohol and other drug abusers. But those providing such treatment for criminal offenders need to recognize that criminal behavior is part of a self-defeating personality, and that these personality traits interfere with the goals of treatment.

Many drug-dependent patients who exhibit criminal behavior have been raised in dysfunctional families, causing the development of self-defeating personality styles. Personality—which develops in childhood and is unconsciously perpetuated in adult life—reflects an individual's habitual way of thinking, feeling, acting, and relating to others. Personality develops as a result of an interaction between genetically inherited traits and family environment. When this interaction is dysfunctional, young people

form self-defeating personality styles that ultimately interfere with their ability to achieve or to maintain abstinence.

Dysfunctional family interactions cause children to develop a distorted view of the world and teach coping methods that may be socially unacceptable. In addition, the family may have been unable to provide guidance to help the child develop the social and occupational skills necessary for successful participation in our complex society. The combined lack of skills and distorted personality functioning may or may not cause addiction to occur. However, these conditions can cause addiction to progress more rapidly. These conditions may also make it difficult for others to recognize the addiction and to encourage the individual to seek treatment during the early stages. Dysfunctional coping methods and self-defeating personality styles interfere with the treatment and recovery processes unless strategies are developed to overcome them.

Treatment strategies—whether they are for primary or for comprehensive treatment programs—are based on one or more of the following components:

- The recognition that alcohol and other drug addiction is a biological, psychological, and social disease
- The recognition that an addicted person needs to achieve lifelong abstinence from all mind-altering drugs
- The development and use of an ongoing recovery program to help the individual maintain abstinence
- The need for diagnosis and treatment of other problems and conditions that can interfere with recovery, including psychological, social, and educational problems

Traditional treatments have taken one of the following approaches: (1) the medical model, which attempts to teach the patient the first three components listed above; or (2) the social/behavioral model, which focuses on the fourth component listed above. However, the most successful treatment approaches are those that are fully comprehensive and place equal emphasis on all four components.

The Recovery Process

Effective treatment combines the best of the medical and social/behavioral models of treatment; it is based on the idea that recovery is a process, taking place over time and having specific stages. Each stage has tasks to be accomplished and skills to be developed. If the patient is unaware of this progression, unable to accomplish the tasks and gain the needed skills, or lacks adequate treatment, relapse is more likely to occur.

For some time, there was no comprehensive treatment approach that focused on how to effectively combat relapse. However, during the 1980s, a number of specialized strategies began to be developed that focused specifically on preventing relapse. The approach described here—the Developmental Model of Recovery—is a comprehensive plan that evolved out of the need to prevent occurrence of the relapsing condition inherent in alcohol and drug dependency.

The Developmental Model of Recovery

The Developmental Model of Recovery has been devised to help recovering people and treatment professionals identify appropriate recovery plans, set treatment goals, and measure progress. This plan describes recovery in terms of the following six stages: (1) transition, (2) stabilization, (3) early recovery, (4) middle recovery, (5) late recovery, and (6) maintenance.

1. Transition stage. The transition stage begins the first time a person experiences a problem related to uncontrolled alcohol or other drug abuse. As the addiction progresses, a series of strategies designed to control use is attempted. This ends with the patient's recognition that safe use of alcohol and/or drugs is no longer possible. The struggle for control is a symptom of a fundamental conflict over personal identity. Denying the extent of their addiction, alcoholics and drug addicts enter this phase of recovery believing they are normal drinkers and drug users who are capable of control. As the progression of addiction causes more severe loss of control, they must redefine their personal identities as addicts who cannot control their use.

During the transition period, the addict will typically attempt periods of both controlled use and abstinence. The periods of abstinence are always short-lived and have the underlying goal of allowing the patient to regain the illusion of being able to control alcohol and other drug use. This illusion may be less important for the criminally involved alcoholic or drug abuser, whose lifestyle and drug abuse are considered normal—and are even encouraged— among his or her peer group.

The major cause of inability to abstain during the transition period is the person's belief that abstinence is unnecessary because there may be a way to control alcohol or other drug use.

2. Stabilization period. During the stabilization period, chemically addicted individuals need to resolve physical withdrawal and other medical problems, learn how to break the psychological conditioning that causes the urge to use alcohol and other drugs, stabilize the crisis that motivated them to seek treatment, and learn to identify and manage symptoms of brain dysfunction. This prepares

them for the long-term rehabilitation processes.

Traditional treatment often underestimates the need to identify these issues and instead focuses primarily on detoxification. Patients find themselves unable to cope with the stress and pressure of brain dysfunction symptoms and physical cravings following detoxification. Many have difficulty gaining much from treatment and feel they are incapable of recovery. They often use alcohol and other drugs to relieve such distress. It takes approximately 6 weeks to 6 months for a patient to control these symptoms, even with the benefit of the correct therapy.

Many criminal offenders experience the lack of a supportive recovery environment, which adds stress and undermines their attempts to stabilize these symptoms. Without a supportive network, offenders have difficulty resisting family, social, and environmental pressures to use alcohol and other drugs.

The major cause of inability to maintain abstinence during the stabilization period is the lack of stabilization management skills.

3. Early recovery period. Early recovery is marked by the need to establish a chemical-free lifestyle. Addicts need to learn about both the addiction and recovery processes. They have to separate from their drug-using friends and build relationships that support their long-term recovery. This may be a very difficult time for criminal justice patients who have never associated with persons who have abstinence-based or drug-free lifestyles.

Patients also need to learn how to develop recovery-based values, thinking, feelings, and behaviors; these must replace values formed in addiction and any antisocial attitudes formed before addiction. The thoughts, feelings, and behaviors developed by the patient with a criminal lifestyle complicate and hinder involvement in appropriate support programs during this period. Major intervention to teach the patient these skills is necessary if success is to be achieved. The period of early recovery lasts approximately 1 to 2 years.

The primary cause of relapse during the early recovery period is a lack of effective social and recovery skills to build a support system.

4. Middle recovery period. Middle recovery is marked by the development of a balanced lifestyle. During this stage, individuals learn to repair past damage done to their lives and relationships.

The recovery program is modified to allow time to reestablish relationships with family, set new vocational goals, and expand social outlets. The patient moves out of the protected environment of the recovery support group to assume a more normal lifestyle. This is a time of stress, as the recovering addict begins applying basic recovery skills to real-life problems.

The major cause of relapse during the middle recovery period is the stress of life change.

5. Late recovery period. During late recovery, the individual makes changes in ongoing personality issues that interfere with life satisfaction. In traditional psychotherapy, this is referred to as self-actualization.

Self-actualization is the process of examining values and goals adopted from parents, culture, and peer groups. Conscious choices are then made about discarding or keeping them or forming new ones. In normal growth and development, this occurs in an individual's mid-20s. For an addict, this process usually occurs 3 to 5 years into the recovery process.

This is the time when criminally involved alcohol and other drug abusers learn to change any unresolved psychological issues which may trigger a relapse to alcohol or other drug use. Examples of these childhood conditions include experiences of emotional, physical, or sexual abuse; abandonment; and cultural limitations on development.

The major cause of relapse during this late phase of recovery is either the inability to cope with the stress of unresolved childhood issues or failure to develop a functional personality style.

6. Maintenance period of recovery. The maintenance period consists of the lifelong process of continued growth and development. This includes coping with adult life transitions, managing routine life problems, and guarding against relapse. The physiology of addiction persists for the rest of an addict's life. Any use of alcohol or other drugs will reactivate the physiological, psychological, and social progression of the disease.

The major cause of relapse during this maintenance period is the failure to maintain a recovery program or the encountering of a major lifestyle transition.

"Stuck Points" in Recovery

Although some patients progress through the six stages of recovery without complications, the majority of individuals addicted to alcohol and other drugs do not. They typically get stuck somewhere in midstream. A "stuck point" is a recovery task that is insurmountable to the individual alcohol and other drug abuser. It can occur during any period of recovery, resulting in failure to complete all the recovery tasks. The eventual consequence is a low-quality condition of abstinence or sobriety.

Generally, a "stuck point" is caused either by lack of skill or lack of confidence in one's ability to complete a recovery task. Other problems occur when a recovering

person encounters a problem—whether physical, psychological, or social—that interferes with the ability to use his or her recovery supports.

When recovering individuals encounter "stuck points," they will either recognize they have a problem and take action, or they will lapse into denial that a problem exists. Without specific relapse-prevention skills to identify and interrupt denial, stress will begin to build. Eventually, the stress will cause a deterioration in functioning that will result in relapse.

Abstinence-Based Symptoms of Addiction During the Recovery Process

The Developmental Model of Recovery recognizes abstinence-based symptoms of addiction that persist well into the recovery process. These symptoms are both physical and psychological effects of the disease of chemical dependency. In the Developmental Model of Recovery, these symptoms must be stabilized and the patient must be taught how to manage them before general rehabilitation can take place. This approach identifies the specific tasks and skills a patient needs to overcome these abstinence-based symptoms of addiction. The approach also has methods and techniques that are geared to the patient's learning needs, psychological problems, and social skills.

1. Post-acute withdrawal. Some of these symptoms are the result of the toxic effects of alcohol and other drugs on the brain. Called post-acute withdrawal symptoms, these are more severe for some patients than they are for others, because certain factors cause stress that aggravate these symptoms. The following conditions—which are common among criminal justice populations—tend to worsen the damage and to aggravate the symptoms caused by alcohol and other drug abuse.

- Physical conditions that worsen post-acute withdrawal through increased brain damage or disrupted brain function include:
  - Combined use of alcohol and other drugs
  - Regular use before age 15 or abusive use for a period of more than 15 years
  - History of head trauma from car accidents, fights, or falling
  - Parental use of alcohol or other drugs during pregnancy
  - Personal or family history of metabolic disease, such as diabetes or hypoglycemia
  - Personal history of malnutrition, usually resulting from alcohol or other drug dependence
  - Physical illness, disease, or chronic pain
- Psychological and social conditions that worsen post-acute withdrawal include:
  - Childhood or adult history of psychological trauma (for example, participant in or victim of sexual or physical violence)
  - Mental illness or severe personality disorder
  - High-stress lifestyle or personality
  - High-stress social environment

2. Addictive preoccupation. The other major area of abstinence-based symptoms is addictive preoccupation—the obsessive thought patterns, compulsive behaviors, and physical cravings caused by the addiction. These behaviors become involuntary, conditioned responses, incorporated into the patient's psychological processes through the gratification the addict associates with drug use. Over time, these behaviors become involuntary, a part of the addict's mental and emotional processes. Unrecognized and uncontrolled, these addictive preoccupations can bring about relapse.

These behaviors are activated by high-risk situations and stress. Addicts leaving the restricted environment of a prison or the close supervision of another correctional facility experience extreme stress in the process of adjusting to and assuming self-responsibility. Added to those stressors are:

- Exposure to alcohol and other drugs or associated paraphernalia
- Exposure to places where alcohol and other drugs are used
- Exposure to other persons with whom the patient has used drugs in the past or to persons who are actively using drugs
- Lack of a stable home environment
- Lack of a stable social environment
- Lack of a stable employment environment

Limits of Traditional Treatment Models

Traditional models of treatment are based on the idea that once a person is detoxified, he or she is capable of fully participating in the treatment process. While this is true during the early stages of addiction for many patients who had led functional lives before their addiction progressed, it is not true for most of the criminal justice population. In addition, most traditional programs have an established regimen that applies to all individuals regardless of education, personality, or social skills. Patients whose needs and strengths correspond with the program usually do well. Those who do not mesh with the program—typically criminal justice patients—generally do not do well.

Traditional treatment focuses on either detoxification by itself or on detoxification followed by a rehabilitation program that is aimed at changing lifestyle. The

program is similar for all patients, regardless of their individual needs and capabilities for recovery. Before realistic lifestyle rehabilitation can occur for criminal justice patients, these patients must learn certain specific stabilization skills. Traditional treatment models do not teach these specific skills.

Compared to the traditional approach, the first step in the Developmental Model of Recovery is to stabilize patients, thereby making it possible for them to take advantage of lifestyle rehabilitation. Patients are then ready to participate in groups with other patients in similar stages of recovery, where they may work on tasks and skills appropriate for that recovery stage. Specific skills are taught to help patients identify and manage the warning signs of potential or imminent relapse.

Principles and Procedures of Relapse Prevention Therapy

The plan for relapse prevention presented here is an appropriate method for helping offenders learn the skills they need to avoid relapse. This systematic approach teaches recovering patients to recognize and manage relapse warning signs. For individuals who are unable to maintain abstinence in spite of primary treatment, relapse prevention becomes the primary focus of treatment efforts.

Recovery and Relapse Processes

Recovery is defined as abstinence plus a full return to biological, psychological, and social functioning. As previously noted, relapse is defined as the process by which a person becomes dysfunctional in recovery, resulting in a return to alcohol and other drug use, physical or emotional collapse, or suicide. Relapse episodes are usually preceded by a series of observable warning signs. In the typical relapse, the patient moves from biological, psychological, and social stability through a period of progressively increasing distress, which then leads to physical or emotional collapse. The symptoms continue to intensify unless the individual turns to the use of alcohol or other drugs for relief.

In order to understand the progression of warning signs, it is important to look at the dynamic interaction between the processes of recovery and relapse. Recovery and relapse are related processes that unfold as the person becomes more self-aware and able to manage behavior on six levels:

- In abstaining from alcohol and other drugs
- In separating from people, places, and things that promote alcohol and other drug use and in establishing a social network that supports recovery
- In stopping self-defeating behaviors that suppress awareness of painful feelings and irrational thoughts
- In learning how to manage feelings and emotions responsibly without resorting to compulsive behavior or the use of alcohol and other drugs
- In learning to change addictive thinking patterns that create painful feelings and self-defeating behaviors
- In identifying and changing mistaken core beliefs about self, others, and the world that promote the use of irrational thinking

When individuals who have had a stable recovery and have done well begin to relapse, they simply reverse this process. In other words, the following sequence occurs.

- The individual has a mistaken belief that causes irrational thoughts.
- The person begins to return to addictive thinking patterns that cause painful feelings.
- These painful feelings cause compulsive, self-defeating behaviors as a way to avoid the feelings.
- The person seeks out situations where there are people who use or where alcohol or other drugs are available.
- The individual finds that he or she is in more pain, thinking more irrationally, and behaving in more irresponsible ways.
- These actions and feelings create a situation in which use seems to be a logical escape from the pain and the individual therefore returns to using alcohol or other drugs.

Basic Principles and Procedures

It is possible to isolate a number of principles that underlie relapse prevention therapy, each of which forms the basis for a specific procedure. Therapists may use these principles and procedures to develop appropriate treatment plans for relapse-prone patients. The key principles of relapse prevention therapy include (1) self-regulation and stabilization, (2) integration and self-assessment, (3) understanding and relapse education, (4) self-knowledge and identification of warning signs, (5) coping skills and management of warning signs, (6) change and recovery planning, (7) awareness and inventory training, (8) involvement of significant others, and (9) maintenance and updating of the relapse prevention plan.

1. Self-regulation and stabilization. The risk of relapse will decrease as the patient's capacity to self-regulate thinking, feeling, memory, judgment, and behavior increases. The goal of self-regulation is achieved through stabilization.

An initial treatment plan should be established that will allow relapse-prone individuals to stabilize physically, psychologically, and socially. The level of stabilization is measured by the person's ability to perform the basic activities of daily living. Because the symptoms of withdrawal are sensitive to stress, it is important to evaluate the individual's level of stability both under high and low stress. Many patients who appear stable in a low-stress environment become unstable when placed in a high-stress environment. The stabilization process often includes:

- Detoxification from alcohol and other drugs
- Recuperation from the effects of debilitating stress that preceded the alcohol and/or other drug use
- Resolution of immediate interpersonal and situational crises that threaten sobriety
- Establishment of a daily structure that includes proper diet, exercise, stress management, and regular contact with both treatment personnel and self-help groups

The risk of alcohol and other drug use is highest during the stabilization period. However, steps may be taken to prevent use. The patient must be in a drug-free environment. Any irrational thoughts that create immediate justification for relapse must be identified and challenged. These relapse justifications must be exposed, analyzed, and challenged by helping the patient to remember the consequences of past alcohol and other drug use and to develop new coping strategies.

The therapist and the patient together can develop an early relapse intervention plan. This plan can establish what steps need to be taken in the event that the patient begins using alcohol and/or other drugs. Such an early intervention plan motivates the patient to stay sober and drug-free, while providing a safety net if drug use occurs.

2. Integration and self-assessment. The risk of relapse will decrease as the patient's level of conscious understanding and acceptance increases about the type of situations and events that led to past relapses. The goal of integrating understanding and acceptance into conscious functioning is achieved through self-assessment.

Self-assessment involves reconstructing in detail the presenting problems and the history of alcohol and other drug use, as well as developing a recovery and relapse history that identifies past causes of relapse. Carefully exploring the presenting problems will identify critical issues that can trigger immediate relapse. This allows the therapist to design crisis- intervention plans that help to solve severely disruptive life problems. The patient may use such problems to justify any relapse during the early stages of treatment.

In reconstructing the recovery/relapse history, it is important to identify the recovery tasks that were completed or ignored and to find the sequence of warning signs that led back to chemical use. The assessment is most effective if the therapist uses homework assignments to reconstruct the relapse history. The patient accomplishes this by making a list of all relapse episodes and identifying the problems that led to relapse. These assignments are then reviewed in group and individual sessions.

3. Understanding and relapse education. The risk of relapse will decrease as the patient's understanding increases about the general factors that cause relapse. This understanding is achieved through an examination of the causes and dynamics of relapse.

Patients prone to relapse need accurate information about what causes relapse and what can be done to prevent it. This is typically provided in structured relapse education sessions and in reading assignments that provide specific information about recovery, relapse, and planning methods for preventing relapse. This information should include, but not be limited to:

- Biological, psychological, and social models of addictive disease
- Model for relapse prevention
- Common "stuck points" in recovery
- Complicating factors in relapse
- Identification of warning signs
- Strategies for managing relapse warning signs
- Planning for effective recovery

It is important to note that patients should be tested to determine their level of retention and comprehension. Many relapse-prone patients have severe memory problems associated with post-acute withdrawal brain dysfunction; such memory problems prevent patients from comprehending or remembering educational information.

4. Self-knowledge and identification of warning signs. The risk of relapse will decrease as the patient's ability to recognize personal relapse warning signs increases. This self-knowledge is achieved through an analysis of each individual patient's relapse sequence.

Identification of warning signs is a process that involves teaching patients (1) to identify the sequence of problems that has led them from stable recovery to drug use in the past, and (2) to then synthesize those steps into an understanding of future circumstances that could cause relapse. The patient develops an individualized list of personal warning signs, which is based on examining his or her own history of irrational thoughts, unmanageable feelings, and self-defeating behaviors.

Most of these lists identify two different types of warning signs:

those related to core psychological issues or residual problems from childhood, and those related to core addictive issues or unresolved problems from the addiction itself. Warning signs related to core psychological issues create pain and dysfunction, but they do not directly cause a person to relapse into drug use.

When patterns of addictive thinking that "justify" relapse are reactivated, a return to drug use occurs. Unresolved core addictive issues provide a person with justification for relapse.

5. Coping skills and management of warning signs. The risk of relapse will decrease as the patient's ability to manage relapse warning signs increases. Relapse-prone patients develop coping skills by learning about self-protective ways of responding to their stressors or warning signs.

To manage warning signs, relapse-prone patients need to be taught how to manage or cope with their warning signs as they occur. Management of warning signs should focus on the following three distinct levels:

- First level (situational-behavioral)—Patients are taught to avoid situations that trigger warning signs and to modify their behavioral responses should those situations arise.
- Second level (cognitive-affective)—At this level, patients are taught to challenge their irrational thoughts and to control the emotional and mental pressures that emerge once a warning sign is activated.
- Third level (core issues)—At this level, patients are taught to identify the core addictive and psychological issues that initially create the warning signs.

6. Change and recovery planning. The risk of relapse will decrease as the patient increasingly relates his or her relapse warning signs to the recommendations of the recovery program. This can be achieved by developing a strategy for recovery.

Recovery planning involves developing a schedule of recovery activities that will help patients to recognize and manage the warning signs that may occur in sobriety. This is done by reviewing each warning sign on the list and ensuring that there is a scheduled recovery activity which focuses on each warning sign.

Each critical warning sign needs to be linked to a specific recovery activity. The activity should address the specific warning sign directly.

7. Awareness and inventory training. The risk of relapse will decrease as the patient increases daily use of inventory techniques that are designed to identify relapse warning signs.

Inventory training involves teaching relapse-prone patients to do daily inventories that monitor compliance with their recovery program and to check for the emergence of relapse warning signs. A morning inventory is used to plan the day. An evening inventory is used to review progress and problems that occurred throughout the day. Whenever possible, these inventories are reviewed by someone who is knowledgeable about the patient and who can assist the patient in looking for any emerging patterns of problems that could trigger relapse.

8. Involvement of significant others. The risk of relapse will decrease as the patient's significant others increase their responsible involvement in recovery and in relapse prevention planning.

Relapse-prone individuals cannot recover alone. They need the help of others. Family members, 12-Step sponsors, counselors, and supportive peers are just a few of the many resources available. The counselor should ensure that others are involved in the recovery. The more directly the significant others are involved in the process of relapse prevention planning, the more likely they are to become productively involved in supporting positive efforts at recoveryand in intervening when relapse warning signs or initial drug use occur.

9. Maintenance and updating of the relapse prevention plan. The risk of relapse decreases if the patient's relapse prevention plan is updated regularly during the first 3 years of abstinence. The relapse prevention plan needs to be updated on a monthly basis for the first 3 months, quarterly for the remainder of the first year, and semiannually for the next 2 years. Once a person has maintained 3 years of uninterrupted abstinence, the relapse prevention plan should be updated on an annual basis.

Patients who have histories of criminal or antisocial behavior may need significantly more frequent reviews. These reviews can provide the supportive structure such patients need during this vulnerable time in the recovery process.

Nearly two-thirds of all relapses occur during the first 6 months of recovery (Maddux and Desmond 1981). Fewer than one-quarter of the variables that actually cause relapse can be predicted during the initial treatment phase. As a result, ongoing outpatient treatment is necessary for effective relapse prevention. Without the ongoing reinforcement of some type of outpatient therapy, even the most effective short-term inpatient or primary outpatient programs will fail to interrupt long-term relapse cycles.

A session to update the relapse prevention plan involves the following:

- Review of the original assessment, list of warning signs, management strategies, and recovery plan
- Update of the original assessment, including any new

documents that are significant to the patient's progress or problems

- Revision of the list of relapse warning signs to incorporate new warning signs that have developed since the previous update
- Development of management strategies for coping with the newly identified warning signs
- Revision of the recovery program to add recovery activities, to address new warning signs, and to eliminate activities that are no longer needed

Alcohol and other drug addiction is viewed as a chronic disease that has a tendency toward relapse. Abstinence from alcohol and other drugs is the recommended goal for all drug addiction treatment. Therefore, all current treatment modalities may benefit by adding relapse prevention programs to their curricula.

Addiction is caused by a cluster of factors—biological, psychological, and social—and requires a battery of approaches to address the complex and individualized manifestation of its symptoms. Relapse prevention is a critical component in comprehensive treatment, which is directly aimed at achieving and maintaining abstinence from alcohol and other drugs.

Chapter 2—Relapse Prevention Approaches in the Criminal Justice System

Roger H. Peters, Ph.D.

The recent increase in new arrestees involved with alcohol and other drugs has placed a significant strain on the criminal justice system and has contributed to overcrowding of jails, prisons, and juvenile detention facilities throughout the country. Information from the Drug Use Forecasting (DUF) system reveals that more than 70 percent of arrestees in many metropolitan areas test positive for drugs (U.S. Department of Justice 1991a). A survey of State and Federal prisons (Frohling 1989) indicates that 62 percent of inmates used drugs on a regular basis prior to incarceration.

Treatment Services for Substance-Abusing Offenders

Despite widespread alcohol and other drug abuse among offenders, few inmates surveyed in jails and prisons report receiving treatment services prior to entering the criminal justice system. Most offenders remain untreated even after identification of their alcohol and other drug abuse problems within the criminal justice system. Only 11 percent of jail inmates referred for drug treatment in metropolitan jails reported prior treatment for alcohol abuse, and only 31 percent reported receiving prior treatment for other drug abuse (Peters and May 1992, p. 38).

Extent of Treatment Among Offenders

A recent survey conducted by the American Jail Association (Peters et al. 1990) found that fewer than 7 percent of an average daily population of 192,461 jail inmates represented in the survey were receiving drug treatment services. Among State prison inmates sampled, only 6 percent reported that they were currently enrolled in drug treatment (U.S. Department of Justice 1988). These findings reflect important gaps in treatment services and inadequate continuity of care for drug-dependent offenders identified within the criminal justice system.

Offenders often do not seek assistance from community alcohol and drug abuse treatment programs because of their denial of substance abuse problems, lack of funds or insurance, and inadequate knowledge about community treatment resources. Recent findings (U.S. Department of Justice 1991a) indicate that young male offenders (aged 15 to 25) are most likely to deny the need for alcohol and other drug abuse treatment.

Drug-involved offenders have extremely limited experience in receiving health care services. They often lack basic skills related to setting and keeping appointments and negotiating for reduced fees according to ability to pay. Offenders often distrust drug abuse treatment providers because of their negative experiences with other social service providers (e.g., child protection teams), their belief that community treatment programs are affiliated with the criminal justice system, and their lack of knowledge about client confidentiality. Within the context of poverty, unemployment, crime, and severe psychosocial problems experienced in many urban areas, peers and family members may not recognize or may devalue an offender's need for alcohol and other drug abuse treatment. Within some cultural groups, being involved in alcohol and other drug abuse or mental health treatment is perceived as a sign of weakness and of inability to cope with stress.

Intervention Goals with Substance-Abusing Offenders

A primary goal in successfully intervening with the substance-abusing offender is to establish continuing care following release from the criminal justice system, according to the National Institute of Corrections Task Force on Correctional Substance Abuse Strategies (U.S. Department of Justice 1991b). Efforts to coordinate a plan of ongoing services requires the cooperation of the court, in-jail program staff, community treatment staff, and community supervision officers, as well as involvement of the offender and available family members. These

activities should begin soon after the alcohol and other drug dependency is identified and well before the offender is released from incarceration. In the absence of leverage imposed by the criminal justice system, offenders have a poor record of continuing in alcohol and other drug abuse treatment (Wexler et al. 1988). Premature dropout among offenders is sometimes related to a lack of awareness of the amount of effort, self-disclosure, and self-discipline required to complete treatment and to the low tolerance for frustration shown by many offenders.

Unless they are exposed to drug treatment within the criminal justice system or to coordinated treatment services in the community, the vast majority of serious drug abusers will return to the community without the skills to prevent relapse to alcohol and other drug abuse. These individuals are extremely likely to reoffend and to return to jails and prisons (Wexler et al. 1988).

Relapse to drug use among this population tends to accelerate the level of subsequent criminal activity. Active drug users are involved in approximately three to five times the number of crime days as nondrug users and are arrested significantly more frequently (Anglin and Speckart 1984). Efforts to break the cycle of drug use among offenders released to the community appear likely to reduce the criminal activity of drug addicts and to ease the overcrowding in local, State, and Federal correctional facilities.

Prevention of Relapse Among Offenders

Most offenders do not actively plan or seek out an addictive lifestyle. More often it is the *lack* of planning, development of personal objectives, and self-monitoring that leads to alcohol and other drug abuse. Many offenders attempt to quit one or more times after developing a chemical dependency problem. However, abstention from drug use is often unsuccessful unless the person has developed relapse prevention skills. Such skills include strategies to deal with recurrent thoughts, cravings, or physical desires to use drugs; strategies to deal with positive expectations about the initial effects of drug use; and strategies to monitor relapse warning signs, to handle high-risk situations, to build drug-free friendships, and to adopt a more balanced lifestyle.

Personal Factors Contributing to Relapse

Among offenders, several factors contribute to the relapse to alcohol and other drug abuse. These include:

- Inadequate skills to deal with the social pressure to use
- Frequent exposure to "high-risk situations" that have led to drug or alcohol use in the past
- Physical or psychological reminders of past drug use (e.g., drug paraphernalia, drug-using friends, money)
- Inadequate skills to deal with interpersonal conflict or negative emotions
- Desire to test their personal control over drug use
- Recurrent thoughts or physical desire to use drugs
- Other stressors related to their return to the community and placement under criminal justice supervision

The majority of drug-involved offenders experience multiple and long-standing psychosocial problems that also contribute to relapse. These include difficulties in relating to family members, an inability to sustain long-term relationships, emotional and psychological difficulties, deficits in educational and vocational skills, employment problems, and multiple contacts with the criminal justice system.

Other skill deficits commonly associated with relapse among offenders include the inability to manage anger and stress, as well as the inability to handle social pressures for drug use and other high-risk situations that are conducive to relapse. Drug-involved offenders have experienced chronic difficulties in successfully dealing with family, employment, and emotional problems. This background of chronic difficulties often leads to reduced self-esteem, anxiety, depression, enhanced expectations about the initial use of drugs or alcohol, and attempts to relieve negative emotions through alcohol and other drug abuse. Past relapse experiences also serve to reinforce the offender's negative self-image as a failure and an addict; they reduce the likelihood that the offender will select nondrug coping strategies when faced with conflict or stress.

High-Risk Situations Contributing to Relapse

Offenders experience a range of situations that create high risk for relapse to alcohol and other drug abuse. Marlatt and Gordon (1985) describe several types of situations that commonly lead to relapse among individuals released from treatment. These include situations experienced with others, such as social pressures to use drugs, and situations experienced alone, such as sudden urges to use drugs or feelings of anxiety or depression. Marlatt and Gordon report that the highest proportion of high-risk situations for alcoholics involves interpersonal, negative emotional states (38 percent), while the highest proportion of high-risk situations reported by heroin addicts involves social pressure (36 percent).

Drug-abusing offenders have a somewhat different pattern of high-risk situations for relapse than those described by Marlatt and Gordon, according to evaluation results obtained by the Hillsborough County Sheriff's Office Substance Abuse Treatment Program (Peters and Dolente 1991). More than 70 percent of offenders participating in this program described cocaine as the major problem drug. Offenders reported the most frequent high-risk situation for relapse was positive emotional states experienced with others (20 percent), followed closely by positive emotional states experienced alone (15 percent), social pressures (15 percent), urges and temptations (15 percent), and testing of personal control (15 percent).

Cocaine-abusing offenders appear to relapse less frequently than other drug abusers because of interpersonal conflict and negative emotional states. Findings indicate that relapse prevention programs for cocaine-abusing offenders should address strategies for handling positive emotions, overconfidence, and urges to use drugs. Many offenders report that past relapses were caused by desires to celebrate or to test personal control over drug use when things were going particularly well. Findings support the need for cocaine-abusing offenders to monitor their thoughts (e.g., their rationalizations for initial drug or alcohol use and their denial of negative consequences), their feelings, and the behaviors that have led to relapse in the past.

Stressors Related to Release from the Criminal Justice System

Following their release from the criminal justice system, offenders face a variety of stressors that can lead to relapse to alcohol and other drug abuse. Many offenders report feeling overwhelmed by the transition from a highly structured correctional environment—one that offers little opportunity to provide for daily living needs—to a less structured environment following release. At this time of concentrated stress, the offender enters a culture where little or no support exists.

Upon release, most offenders face having no job, no money, and weakened or broken family ties. There are immediate demands to plan daily activities, to begin interacting constructively in nonadversarial relationships, and to manage personal or household finances and problems.

Offenders, especially if they have longstanding alcohol or drug abuse problems, may *never* have learned the skills required to function successfully as an adult family member and productive member of the community. The offender may rapidly return to alcohol and other drug abuse if he or she has not had a chance to learn these skills and to rehearse strategies for coping with these stressors, as well as with pressures at home, on the job, or related to the restrictions imposed by community supervision.

Reunification with family members is one of several important stressors linked to relapse when offenders return to the community. Reunification is often accompanied by stress related to the family's distrust and anger from the offender's past drug use, unresolved conflicts with the partner or spouse, shifting parental roles, and added financial obligations.

Returning to living arrangements with family members who are active alcohol or other drug users or who condone drug use within the home creates additional high-risk situations for relapse. Many offenders return to live in active drug neighborhoods and then face daily pressures to buy and use drugs. The returned offender is continually exposed to reminders of alcohol and other drug abuse. This continued exposure often leads to "covert setups" or situations in which the offender, through a series of seemingly unimportant decisions, places the individual at progressively greater risk for relapse. Ultimately, it is extremely difficult for that person to resist the temptation to use drugs or alcohol.

Returning offenders are also significantly stressed from the sanctions imposed by probation or parole, including house arrest, drug testing, and other surveillance or reporting activities. Following an offender's release from treatment or incarceration, pressures to hold steady employment—often as a condition of probation or parole—cause additional stress. Offenders sometimes return to alcohol and other drug abuse after coming to recognize the full extent of the sanctions or restrictions imposed by community supervision programs, as well as the effort that is required to comply with probation or parole guidelines.

Program Approaches for Preventing Relapse

Several relapse prevention approaches have been developed to assist alcohol and other drug abusers in maintaining motivation and commitment to abstinence after their release from treatment, particularly during the first several months when most relapses occur. These same approaches have been implemented successfully with other addictive disorders. Although research has not examined specific relapse patterns among offenders, it is clear that relapse is an important predictor of subsequent criminal activity among this population.

Assessment of Past Relapses

In preventing relapse among offenders, a key element is the assessment of an individual's past relapse experiences following a period of abstention, as well as the evaluation of coping skills that have worked in the past to help the person manage and avoid relapse. These relapse assessment activities should provide sufficient information to develop an individualized "behavior chain" for each offender, describing the sequence of events leading up to relapse. The behavior chain typically begins with a specific high-risk situation and is followed by thoughts, emotions/feelings, cues (or reminders of alcohol or other drug use), urges, substance abuse behavior, and consequences of this behavior. By developing a relapse behavior chain, the individual establishes a strong foundation for his or her treatment planning and identifies the coping skills needed to address common events that precede relapse.

Other important relapse prevention approaches include:

- Identification and monitoring of high-risk situations and warning signs
- Rehearsal of strategies to manage relapse successfully
- Teaching of techniques for identifying and modifying self-statements that lead to negative emotions or the rationalization of alcohol and other drug abuse behavior
- Teaching of techniques to control drug urges and cues

Additional techniques to promote effective communication, stress and anger management, and problem solving are also useful in addressing interpersonal difficulties that contribute to relapse.

In addition, relapse prevention approaches for offenders should address problems related to social, family, vocational, and psychological functioning. Problems in these areas often create chronic dissatisfaction or anxiety, and the offender may attempt to compensate for these feelings by using drugs or alcohol.

Importance of structured programs. Offenders respond favorably to the structured approach used in relapse prevention programs. Many offenders report that these programs provide their first opportunity to realize the similarities among past relapses and to establish a framework for understanding how to interrupt the relapse process. Relapse prevention programs focus on educational approaches and the rehearsal of coping skills, which stimulates participation by offenders who have difficulty in handling confrontation and encourages offenders to take responsibility for their own recovery.

The principles of self-empowerment are inherent in structured relapse prevention approaches. This self-empowerment philosophy provides a means for staff to develop trust and rapport with offenders during the initial stages of treatment. It is especially helpful for staff members who have limited experience or training in alcohol and other drug abuse treatment with offenders.

Timing of relapse prevention activities. Alcohol and other drug abuse treatment programs within the criminal justice system need to provide relapse prevention activities well in advance of an offender's expected release/completion date. Sufficient time should be allowed for the offender to rehearse relapse coping skills, including self-monitoring of thoughts, problem emotions, and behaviors that have led to relapse in the past, and to identify and rehearse strategies for dealing with important high-risk situations that are likely to be encountered following release. It is useful for offenders to anticipate potential relapse situations that might occur on the first several days after release from treatment. They also need to identify other potential risk factors for relapse that could undermine efforts to stay sober.

Near the end of treatment, the offender should also participate in developing a relapse plan that describes strategies for managing negative thoughts, emotions, or those situations that are most likely to lead to renewed alcohol or other drug use. A reminder or "sobriety card" can be developed that will list several immediate strategies for avoiding relapse. Such a reminder is quite useful for dealing with unanticipated high-risk situations that occur following release from treatment.

Need for follow-up care in the community. All the work to develop relapse prevention skills within a structured criminal justice setting can be rendered ineffective if the offender does not practice or choose to use these skills following release. Many offenders are released from jail or prison without provision for any follow-up care. Under these circumstances, it is unrealistic to expect that offenders will continue to practice relapse prevention techniques.

To provide continuity of relapse prevention programming for offenders leaving prison or jail, treatment programs must be identified in the community that offer similar approaches and experiences. Offenders need to have ongoing involvement in relapse prevention activities following their release from treatment in the criminal justice system. This continued involvement provides a critical opportunity for them to test out their coping skills in real situations and to review the effectiveness of their own responses to high-risk situations while being assisted by counselors and other group members.

Advantages of joint staff training. In-custody and community drug treatment staffs need to be involved in joint training activities on relapse prevention, since this provides an effective bridge to supervised release. Joint training promotes a shared understanding of the common relapse triggers and warning signs experienced by offenders. In some jurisdictions, probation and parole officers have also been trained in relapse prevention strategies and have participated effectively in treatment teams.

Combining supervision staff and community drug treatment staff in relapse prevention training and in treatment activities can result in the following advantages:

- Greater clarity in the development of treatment and recovery goals
- Development of a common vocabulary to review an offender's progress
- More accurate identification of early warning signs for relapse

Several jurisdictions have designed specialized probation and parole caseloads for drug-involved offenders that provide further opportunities for monitoring and preventing relapse.

Structured Program Strategies to Aid Community Reentry

Several structural elements of treatment programs developed within the criminal justice system can assist in preventing relapse among drug-abusing offenders. Graduated reentry to the community is an important component of offender drug treatment; this helps to prevent relapse during the critical first several months after release from custody or close supervision. Successful drug treatment programs within the criminal justice system assist offenders in the transition to the community and encourage contact with a range of follow-up treatment services (including self-help groups) to ensure adherence to the recovery plan. Anglin (1988) reviewed findings from the California Civil Addict Program. He concluded that initial substance abuse treatment efforts need to be coupled with a lengthy period of follow-up treatment; he also concluded that frequent monitoring and drug testing need to be conducted during the follow-up treatment period.

In programs designed for incarcerated offenders, staffs have found it useful to invite counselors from community drug treatment agencies to visit the drug treatment program and to discuss issues of mutual concern, such as residential and outpatient services available upon release, fee structures, and the coordination of aftercare services with probation or parole officers.

The offender's relapse prevention plan, aftercare treatment plan, assessment information, and information describing participation in treatment should be made available to the community treatment providers and to probation and parole staff. When the offender and treatment staff meet to develop and coordinate the post-release treatment plan, it is often useful to involve a community treatment counselor in the meetings.

Because offenders have limited experience in community drug treatment, it is important to establish an initial appointment for the offender to start follow-up treatment well in advance of the person's release from the program. It is also important to provide post-release monitoring to determine whether an offender has attended the recommended treatment sessions.

In many jurisdictions, independent programs such as TASC (Treatment Alternatives to Street Crime) have been developed to establish linkages between the criminal justice system and the alcohol and drug abuse treatment community. These programs provide early identification, assessment, referral, and case management of drug-involved offenders to ensure that offenders receive needed treatment in jail or in the community.

Counselors from these programs sometimes work with offenders prior to release from incarceration or in-jail treatment. To streamline the process of admission to community treatment, these counselors can provide intake assessment for community treatment agencies. These counselors also provide referral to incustody treatment programs, assist the court in designating appropriate drug treatment services as a condition of probation or as part of deferred prosecution arrangements, and work with probation officers to monitor progress in treatment and drug testing.

Other jurisdictions prefer case management procedures that operate under the supervision of the courts or by procedures established through statutory guidelines. Such statutory guidelines include Colorado's H.B. 91-1173, enacted in 1991, which is designed to establish statewide uniform standards of drug abuse assessment and treatment for all offenders involved in the State's criminal justice systems.

Role of Pretrial Alcohol and Other Drug Abuse Programs

Pretrial alcohol and other drug abuse programs provide an important opportunity to involve the drug-abusing offender in early stages of treatment, to provide graduated reentry to the community, and to prevent relapse during the first few months after release. It is important for these

programs to develop procedures for informing the court and community supervision staff about an offender's participation and progress in treatment. For in-jail treatment programs, these procedures are useful in preventing unexpected release on bond or recognizance. In some jail treatment programs, notice of an inmate's participation in treatment and a recommended aftercare treatment plan are forwarded to the judge, public defender, State's attorney, and probation officer. This clarifies the anticipated date of completion from the treatment program and assists the court in addressing follow-up treatment needs prior to the inmate's return to the community.

Treatment programs within the criminal justice system should also work closely with the court and probation officers to develop graduated sanctions for offenders who violate program rules or conditions of probation, or who test positive for alcohol and/or other drugs. These sanctions should be developed with the recognition that relapse is an expected symptom of chemical dependency, and that several relapses may occur before an offender becomes abstinent. Whenever possible, program guidelines should be structured to provide enhanced supervision and more intensive involvement in treatment as an alternative to re-arrest.

Court-Ordered Treatment

Court-ordered treatment for alcohol and other drug abuse can assist in providing the offender with an initial exposure to treatment services and then to continuity of care between incarceration and follow-up community treatment. The court, during pretrial hearings and at the time of sentencing, should address the offender's need to be involved in alcohol and other drug abuse treatment. Some jurisdictions have developed "drug courts," a division of the court focusing on the handling of drug cases. Judges and probation officers work closely together to monitor offenders who are receiving treatment as a condition of diversion or probation.

In some jurisdictions, judges may sentence drug-dependent offenders to be assessed for involvement in jail treatment programs. Split sentences are provided in many such jurisdictions. These require that the offender participate in and complete jail treatment programs, followed by a similar involvement in community treatment.

Follow-up treatment in the community is often stipulated by the court as a condition of probation or parole. Courts knowledgeable about relapse prevention programming can play a pivotal role in developing continuity of treatment for offenders after their participation in a jail treatment program. Requiring the substance-abusing offender to participate in relapse prevention programs can provide the difference between successful recovery and relapse to alcohol and other drug use.

An offender's motivation and commitment to an abstinent lifestyle often subsides following release from treatment within the criminal justice system. To counteract this, court-ordered treatment, drug testing, and community supervision can provide important incentives to sustain involvement in the recovery process until the individual's internal motivations can be strengthened. Such internal motivation can be engendered through peer support, confrontation, and the offender's examining of thoughts and behaviors related to relapse. Research indicates that court-ordered treatment is an effective vehicle for preventing relapse and recidivism among drug-abusing offenders who are unlikely to attend treatment on their own (Anglin 1988). The short-term treatment outcomes of offenders who participate in court-supervised drug treatment are comparable to those of voluntary clients (Maddux 1988; Simpson and Marsh 1988).

Court-ordered treatment also tends to increase offenders' involvement in community treatment and the length of time in treatment (Hubbard et al. 1988), particularly for offenders in residential treatment. An offender's participation in community treatment is further strengthened by involvement in a TASC program (Collins and Allison 1983; Hubbard et al. 1988).

Evaluation of Relapse Prevention Programs

Relapse prevention programs designed for drug-abusing offenders need to be evaluated for their effectiveness. Such evaluation is vital in determining what effect treatment interventions have on whether offenders return to drug use and to criminal behavior. Research has demonstrated the effectiveness of relapse prevention approaches among a variety of alcohol- and other drug-abusing populations; research also supports the use of these approaches with offenders.

The Bureau of Justice Assistance recently funded a demonstration program to establish three demonstration drug treatment programs in jails, including a relapse prevention program within the Hillsborough County Jail in Tampa, Florida. This 6-week program is designed to help sentenced offenders by strengthening their motivation and commitment to treatment, providing

individual assessment of their alcohol and other drug abuse and relapse history, developing a foundation of relapse prevention skills, and providing linkages to community treatment following release from jail. (See Chapter 3 for a summary of this program.)

Findings from an ongoing evaluation of the program indicate that inmates who complete the treatment program are arrested significantly less frequently in the year following release from jail, compared to a group of untreated, drug-involved inmates. Compared to untreated offenders, those participating in relapse prevention treatment also remain significantly longer in the community before arrest and spend fewer days in jail during the 1-year follow-up period. Over the course of relapse prevention treatment, offenders participating in the program show significant improvement on measures of coping skills in high-risk situations that could trigger alcohol and drug abuse relapse. Program participants also show increased knowledge about principles of recovery and of relapse prevention.

Although preliminary evaluation results appear to be quite promising, further evaluation is needed. Such study should examine the sequence and intensity of relapse prevention approaches needed within different criminal justice settings, the importance for offenders of rehearsing coping skills following release from treatment, and the further identification of those high-risk situations most likely to lead to relapse and criminal recidivism.

Chapter 3—Examples of Relapse Prevention Approaches

Relapse prevention techniques can be an important addition to programs serving offenders at all levels—local, county, State, and Federal, and these techniques are appropriate at all case-processing points in the criminal justice system. Following are examples of relapse prevention approaches used by a number of local, State, and Federal criminal justice agencies. This selection of examples represents programs from all case-processing points in the criminal justice system diversion, probation, jail, intermediate sanctions, corrections, and parole. Information on these examples was gathered by Roger H. Peters, Ph.D., in conjunction with his research into and development of relapse prevention methods used in criminal justice settings.

Individual Local/County/ Regional Programs

Bexar County Adult Probation Drug/Alcohol Custodial Treatment Facility
San Antonio, Texas

Bexar County Adult Probation Drug/Alcohol Custodial Treatment Facility is a co-educational treatment program that combines alcohol and other drug abuse treatment with various relapse prevention methods in a 30-day residential program. Admission is based either on court-ordered treatment as a diversion from imprisonment or on treatment as a condition of probation supervision. Relapse prevention sessions begin the first week of the program and include help for offenders in:

- Identifying cravings, stress triggers, and high-risk situations
- Identifying relapse warning signs
- Developing coping strategies

The curriculum includes sessions on AIDS education, parenting skills, family planning, and life skills. For women, the program provides special relapse prevention sessions that focus on their specific needs. Sessions are provided by in-house counselors as well as through linkages with other community-based services.

Contact: Wayne A. Marshall, Program Director, Bexar County Adult Probation Drug/Alcohol Custodial Treatment Facility, 10975 Applewhite Road, Route 5, Box 340, San Antonio, Texas 78221, phone (512) 628-1080.

Central Texas Parole Violators Facility Chemical Dependency Treatment Program
San Antonio, Texas

The Central Texas Parole Violators Facility (CTPVF) Chemical Dependency Treatment Program is a 70- to 90-day in-jail treatment program. The program focuses on relapse prevention planning for inmates whose parole has been rescinded, usually because of relapse to alcohol and other drug abuse. Following an initial assessment and admission screening that uses the Relapse Probability Scale, the program is voluntary.

Relapse prevention sessions, held 5 days a week for 2 hours each, are provided as a supplement to other treatment modalities that the participants may have experienced in the past. The sessions help participants to identify high-risk situations and to develop coping strategies, as well as reinforcing their sense of individual responsibility. Other sessions within the program cover AIDS education, dysfunctional family dynamics, parenting skills, and general alcohol and drug abuse education based on the biopsychosocial model of abuse.

The CTPVF Chemical Dependency Treatment Program is made up of a 40-member male group and a 38-member female group. The curriculum for women is enhanced by sessions that focus on self-esteem, independence within intimate relationships, fulfillment of goals, and spousal and domestic violence.

Contact: Eveline Conley, Program Coordinator, Wackenhut Corrections Corporation, Central Texas Parole Violators Facility Chemical Dependency Treatment Program, 218 South Laredo,

San Antonio, Texas 78207, phone (512) 227-5600.

Center for Alternative Sentencing and Employment Services *New York, New York*

The Center for Alternative Sentencing and Employment Services (CASES) administers two programs that provide alternative supervision of offenders in New York City—the Community Service Sentencing Project (CSSP) and the Court Employment Project (CEP). CSSP is a program of unpaid community service that the court can impose on persistent, non-violent misdemeanor offenders instead of sentencing them to jail. CEP operates two programs in the Supreme Court for young felony offenders facing incarceration:. the Daily Supervision Program and Working Solutions. Daily Supervision participants are required to be involved in at least 20 hours of structured activity each week, while participants in the Working Solutions program attend a daytime reporting center and take part in counseling, academic training, and pre-employment and construction skills training.

CASES includes an in-house relapse prevention unit for all participants who have been detoxified and assessed as being at risk for relapse. The curriculum consists of four 2-hour sessions held over a 4-week period. Following completion of a core curriculum, participants are required to attend followup group sessions that focus on:

- Resisting social pressure and developing refusal skills
- Breaking off relationships with active users
- Structuring leisure time and building new relationships
- Developing a long-range plan for abstinence

Contact: Joe McLaughlin, Program Director, The Center for Alternative Sentencing and Employment Services, 346 Broadway Avenue, New York, New York 10013, phone (212) 732-0076.

D.E.U.C.E. (Deciding, Educating, Understanding, Counseling, Evaluating) *Martinez, California*

D.E.U.C.E. is a 90-day residential program operating in the Contra Costa County jails for the purpose of preventing further alcohol and other drug abuse and the criminal activity that supports such abuse. Treatment is combined with relapse prevention planning. Relapse prevention techniques are woven into each of two tracks of the structured 6-hour per day curriculum. Track I uses a process model to focus on substance abuse; Track II focuses on the individual's recovery plan.

D.E.U.C.E. assesses the probability of relapse and uses this information combined with the client's history to develop an individualized plan for relapse prevention. Each participant is required to develop a written relapse prevention plan, as well as relapse warning cards based on the person's identified relapse history and relapsing behaviors. The last phase of the program fully focuses on relapse prevention methods and arranges for linkages with community-based support.

Contact: Mary Lou Browning, Project D.E.U.C.E., Contra Costa County Detention Facility, Adult Education Program, 1000 Ward Street, Martinez, California 94553, phone (415) 646-4669.

Essex Bail/Bond Agency *Newark, New Jersey*

The Essex Bail/Bond Agency seeks to keep the pretrial detainees it has bonded from committing new offenses and to assure their appearance at scheduled court dates. The program focuses on alcohol- and other drug-abusing offenders who are charged with felonies as well as with misdemeanor offenses; those having a history of criminal violence are considered inappropriate for the program.

The agency maintains strict control over the detainees by helping them obtain jobs, education, drug treatment, and other services. Maintaining the statutory power of the private bail bondsman, the agency has the authority to surrender its detainees to the custody of the sheriff for failure to appear in court. This authority enables the enforcement of a "release contract," which includes requirements for a curfew, treatment, and employment. The program has eight elements:

- Screening
- Transitional residence
- Close monitoring
- Provision of services
- Relapse prevention counseling
- Cognitive skills training
- Court appearances
- Sentencing information

In-house drug treatment consists of a 4-week program that requires five evening counseling sessions per week. Detainees work through a 20-lesson curriculum in which they learn cognitive and behavioral skills for avoiding relapse.

Contact: Luis A. Torres, Senior Planner, Vera Institute of Justice, Inc., The Essex Bail/Bond Agency, 155 Washington Street, Newark, New Jersey 07102, phone (212) 334-1300.

Hillsborough County Sheriff's Office Substance Abuse Treatment Program *Tampa, Florida*

The Hillsborough County Sheriff's Office Substance Abuse Treatment Program gives priority to alcohol and other drug abusers who have been court-ordered into treatment. The 6-week residential program is based on the relapse prevention

model; it is enhanced by a battery of assessment instruments developed by program staff. In the early stages of the program, the Substance Abuse Relapse Assessment (S.A.R.A.) identifies antecedents to alcohol and other drug abuse, patterns and consequences of use, and existing coping skills. The Inventory of Substance Use Situations and Determinants of Drug Use is used to assess relapse determinants. A Relapse Prevention Skills Test is useful in the advanced stages of the program to assess whether participants have acquired relapse prevention skills.

The curriculum emphasizes the development of individualized coping skills for high-risk situations; the skills are modeled and rehearsed in role playing and with group feedback. Aftercare is arranged through TASC (Treatment Alternatives to Street Crime) and through treatment services purchased by the Florida Department of Corrections.

Contact: Roger H. Peters, Ph.D., Assistant Professor, University of South Florida, Florida Mental Health Institute, Department of Law and Mental Health, 13301 N. Bruce B. Downs Boulevard, Tampa, Florida 33612-3899, phone (813) 974-4510, or Jan Bates, Inmate Program Supervisor, Hillsborough County Sheriff's Office Substance Abuse Treatment Program, Hillsborough County Jail, Tampa, Florida 33612-3899, phone (813) 247-8488.

Florida Department of Corrections Programs

The following seven programs are currently operated within the Florida Department of Corrections. Each program includes four levels of intensity, and all include some method for preventing relapse. Tier I provides alcohol and drug abuse prevention education in a 4-week program. Tier II offers a drug intervention program conducted in a modified therapeutic community over a period of 8 weeks to 4 months. Tier III is a 9-month, full-service therapeutic community drug intervention program. Tier IV is a 4-week relapse prevention and reentry program conducted in a community-based setting.

For more information on any of the Florida Department of Corrections relapse prevention modalities, contact: Jennifer Bevino, Substance Director, Substance Abuse Programs, Florida Department of Corrections, 2601 Blairstone Road, Tallahassee, Florida 32399-2500, phone (904) 488-9169.

Tier II: Drug Intervention Center Martin Correctional Institution
Indiantown, Florida

The Drug Intervention Center is a rigorous, voluntary 4-month program for alcohol- and drug-abusing inmates serving sentences of 3 years or less for nonviolent crimes. Sessions take place from 8 a.m. to 9 p.m. Monday through Friday and from 8 a.m. to 5 p.m. on Saturdays. Phase I consists of 2 weeks of program orientation followed by Phase II, a 4-week focus on developing lifeskills and understanding addiction and the recovery process. Phase III prepares the participant for reintegration; the participant, with counselor assistance, develops an aftercare plan and relapse contract. High-risk situations, triggers, and individuals are identified; action plans to counter those triggers are developed and enacted. In preparation for release, participants develop a list of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) sponsors. The list contains AA/NA telephone numbers for participants to carry with them at all times along with several quarters reserved for "emergency support" phone calls to those sponsors. The Center makes referrals to halfway houses, vocational and educational programs, and other self-help or support groups.

Tier II: Substance Abuse Treatment Unit Lake Correctional Institution
Clermont, Florida

The Substance Abuse Treatment Unit is a voluntary, 4-month program for alcohol and other drug abusers serving short sentences; the nature of the offense is not an admission factor. Based on the 12-Step program and behavior modification methods, the program seeks to change self-defeating thought patterns and emotional reactions. During the second month of treatment, the program emphasizes relapse prevention training. The specialized sessions on relapse prevention include: Slips in Narcotics Anonymous, Understanding Relapsing Attitudes, Behaviors and Feelings, and Ten Most Common Dangers. This program has identified the lack of job skills, stress associated with finding employment, and family crisis as being among the most critical antecedents of relapse. Referrals are made for aftercare and support services following release from custody.

Tier II: Women's Drug Treatment Unit Florida Correctional Institution
Lowell, Florida

The Women's Drug Treatment Unit builds on relapse prevention education provided in Tier I. Videotapes, discussions, and identification of relapse triggers form the basis for the development

of coping strategies. The program also uses Gestalt methods for role playing and reenacting events leading to full relapse. Special focus is given to coping with spousal or domestic abuse, alcohol and other drug abuse by spouse or a partner, drug-abusing families, and economic dependence as critical factors leading to relapse among women. This program has also found art therapy and story writing to be useful exercises for identifying areas of negative self-image.

Tier III: "Doin' Time Gettin' Straight" Marion Correctional Institution *Lowell, Florida*

"Doin' Time Gettin' Straight" is a 9-month program in which relapse prevention training begins in the fourth month of treatment. The relapse prevention model forms the basis for the largely instructional format. Role playing and behavior rehearsal are used to develop coping strategies, while clinical attention is given to identified high-risk situations and relapse triggers.

Other sessions address unresolved anger and irrational thought patterns underlying alcohol and other drug abuse behaviors. Relapse prevention plans are developed in the sixth month of treatment in preparation for release from custody; these plans are coordinated with community- based treatment in the seventh and eighth months of the program.

Tier III: Jones Cottage Drug Treatment Program Florida Correctional Institution *Lowell, Florida*

The Jones Cottage Drug Treatment Program includes relapse prevention methods in the program orientation and also incorporates them into the daily operation of the program. To help diffuse their fear of relapse, participants learn to identify their individual high-risk situations and triggers. Role play follows to develop coping strategies.

This program has identified the lack of job skills and the stress associated with finding employment as being critical antecedents to relapse. Relapse prevention education is conducted through lectures, discussion groups, handouts, self-tests, and workbooks. In addition, all program participants hold each other accountable for relapse behavior within the program dormitory.

Tier IV: Drug Abuse Treatment Program Tallahassee Community Correctional Center *Tallahassee, Florida*

The Drug Abuse Treatment Program begins relapse prevention training between the third and seventh weeks of the treatment program. The program places special emphasis on examining the triggering events and set-up behaviors that lower resistance to triggers and cravings for alcohol and other drugs. Participants develop coping strategies through exercises that are designed to control euphoric recall and the projection of past and potential future drug experiences.

This program has identified boredom due to a lack of goals—or goals that are not clearly defined—as being a critical antecedent to relapse. The program provides sessions on establishing and fulfilling realistic goals as a counter to this high-risk situation, which is common to alcohol and other drug abusers who lack employable skills.

Tier IV: Drug Treatment Unit Cocoa Community Corrections Center *Sharpes, Florida*

This Florida Drug Treatment Unit provides a program required by the Florida Department of Corrections as part of its work release program. This correctional facility develops all its relapse prevention strategies to correspond with the individual participant's identified high-risk situations and triggers, as well as the individual's motivation and comprehension, and the strength of the person's support system. Each inmate is required to develop and sign a relapse prevention contract with himself, and then to involve a significant, supportive individual in monitoring fulfillment of the contract.

Activities and sessions are designed to produce behavior and attitude changes relating to the participants' alcohol and other drug use and involvement with criminal activity. This program, which permits inmates to enter the community to maintain employment on work release, has identified resistance to breaking free of alcohol- and other drug-using friends and associates, particularly in the hours immediately following the workday, as the most significant trigger and high-risk situation.

Federal Bureau of Prisons Programs

The following three programs have been developed in individual correctional facilities of the Federal Bureau of Prisons. Each program purchases transitional treatment services from the community to which the program participants will return after their release from Federal custody. The National Institute on Drug Abuse is

evaluating the effectiveness of each of these programs.

For more information on any of the following programs, as well as others being developed by the Federal prisons system, contact: Drug Abuse Programs Central Office, Federal Bureau of Prisons, 320 First Street, N.W., Room 301 NALC, Washington, D.C. 20534, phone (202) 633-2214.

Women's Substance Abuse Treatment Unit Federal Correctional Institution *Lexington, Kentucky*

The Women's Substance Abuse Treatment Unit is a voluntary, 12-month program in which the final 3 months are devoted to preparing for relapse prevention. The program is based on the relapse prevention model; it is enhanced by sessions in which alcohol and other drug cravings are graphically confronted and tested. Women develop coping and resistance strategies as an outcome of these confrontations. The program also focuses on the special needs of women alcohol and other drug abusers. It provides intensive sessions on how to resolve issues related to abusive and co-dependent relationships with alcohol- and drug-abusing men and parents. Other sessions focus on the issues surrounding sexual or physical abuse. Program plans call for offering future sessions on family counseling.

Comprehensive Drug Treatment Program Federal Correctional Institution *Oxford, Wisconsin*

The Comprehensive Drug Treatment Program is a voluntary, 9-month program; relapse prevention concepts are presented as advances in the treatment of alcohol and other drug abuse that will work successfully with all other treatment models. Sessions focus on defining the stages leading to full-blown relapse and on the differences between a lapse, a slip, and a full relapse to uncontrolled alcohol or other drug abuse.

Through analyzing each participant's prior relapse history, high-risk situations and triggers are identified. Using group role playing and feedback, individuals then develop coping strategies to counter those situations. Other sessions delve into personality characteristics that are related to relapsing behaviors.

Pilot Drug Abuse Treatment Program Federal Correctional Institution *Tallahassee, Florida*

The Pilot Drug Abuse Treatment Program provides training in relapse prevention for men in 10 sessions that have a specialized focus. These sessions include: Coping with Observations of Use/Distribution by Others, Coping with Lapses, Coping with Offers to Use, and The Role of Helpers in Relapse Prevention.

The program uses a battery of relapse assessment instruments, including an Inventory of Drinking Situations. The use of legal drugs, such as alcohol, has been identified by this program as one critical high-risk factor in relapse. Several methods are used to develop coping strategies, including imagery exercises, role playing, and written plans.

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